

Telehealth: Current Barriers, Potential Progress

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TABLE OF CONTENTS

I. INTRODUCTION	409
II. BACKGROUND AND BENEFITS OF TELEHEALTH	412
A. <i>The Current Climate of Health Care in the United States</i> ...	413
B. <i>What Is Telehealth?</i>	415
C. <i>The Potential Benefits of Telehealth on the Health Care System of the United States</i>	417
III. CURRENT REGULATIONS AND BARRIERS	419
A. <i>State Regulation and Coverage</i>	420
1. <i>Physician Licensure</i>	421
2. <i>Reimbursement for Telehealth Services</i>	425
3. <i>Other Legal Impediments to Telehealth on the State Level</i>	427
B. <i>Federal Regulation and Coverage</i>	428
1. <i>Medicare and Medicaid Reimbursement for Telehealth</i>	428
2. <i>The Affordable Care Act</i>	430
IV. FEDERAL ACTION ENCOURAGING THE GROWTH OF TELEHEALTH	431
A. <i>Suggested Federal Regulation</i>	431
1. <i>National Licensure for Telehealth Services</i>	432
2. <i>Expanding the Telehealth Services that Can Be Reimbursed Through Federal Programs</i>	435
B. <i>The Constitutionality of Federal Regulations Regarding Telehealth</i>	436
V. CONCLUSION	438

I. INTRODUCTION

Imagine an eighty-year-old man recently diagnosed with chronic heart disease. He is unable to take care of himself, and his family has realized that they sadly do not have the means or the time to provide the treatment and monitoring necessary to control his condition at home. Despite wishing to remain independent, the man does not have the money to pay out-of-pocket for home health care, and because he is not “homebound,” Medicare will not

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cover home health services.¹ The man will have to go into a nursing home where staff can frequently check his symptoms and vital signs.

If this man were a veteran, moving into a nursing home may not have been as necessary. Home telehealth technologies allow the Department of Veterans Affairs (VA) hospitals to use video technology and messaging devices to collect information about patients' vital signs and symptoms without requiring the patient to leave his home.² A care coordinator, usually a nurse or social worker, is able to monitor the veteran and connect with primary care physicians to arrange treatment changes, set up appointments, or arrange hospital admissions.³ Thousands of veterans with health problems are able to live in the comfort of their own homes because of the availability of home telehealth devices to coordinate their care.⁴

The Department of Veterans Affairs has reported a 35% reduction in hospital admissions and a 59% reduction in total bed days of care since launching one of the country's first broad telehealth programs in 2003.⁵ While this is the case, surprisingly neither Medicare nor Medicaid reimburse for home telehealth services.⁶ Despite the benefits realized by VA hospitals, and

¹ *Home Health Services*, MEDICARE.GOV, <http://www.medicare.gov/coverage/home-health-services.html> (last visited Jan. 16, 2015), *archived at* <http://perma.cc/REV7-URKD>.

² *Home Telehealth*, U.S. DEP'T OF VETERANS AFF., <http://www.telehealth.va.gov/ccht/> (last visited Jan. 16, 2015), *archived at* <http://perma.cc/AK49-697D>.

³ *Id.*

⁴ *Id.*; see also Susan D. Hall, *AAFP Panel: Telemedicine Can Help Expand Care*, FIERCEHEALTHIT (Feb. 7, 2014), <http://www.fiercehealthit.com/story/aafp-panel-telemedicine-can-help-expand-care/2014-02-07>, *archived at* <http://perma.cc/U47G-KVZB> (stating that telehealth currently enables 90,000 veterans with chronic conditions to live in their homes).

⁵ Hayley Tsukayama, *High-Tech Upgrades May Let Aging Boomers Live Independently in Their Own Homes Longer*, WASH. POST (Jan. 20, 2014), http://www.washingtonpost.com/business/technology/hi-tech-upgrades-may-let-aging-baby-boomers-live-independently-in-their-own-homes-longer/2014/01/20/72e3d3b8-759f-11e3-8b3f-b1666705ca3b_story.html, *archived at* <http://perma.cc/N49V-2EDG> (explaining that the VA saves \$2,000 per year in costs for each patient participating in the telehealth program, "even when factoring in the cost of the program itself"); see also Robert Janek, *Need Help Managing Your Patients' Chronic Disease at Home? Consider VNA of Ohio TeleHealth*, MD NEWS (Feb. 17, 2014), http://www.mdnews.com/news/2014_02/05788-spr14-vna-of-ohio-telehealth.aspx, *archived at* <http://perma.cc/453Y-TVGN> ("VNA [Visiting Nurses Association] of Ohio's statistics for its TeleHealth patients show similar outcomes: 19.85% reduction in emergency care events, 29.78% reduction in inpatient events, and 4.25% reduction in 30-day readmits with same diagnosis.").

⁶ CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUMAN SERVS., TELEHEALTH SERVICES: RURAL HEALTH FACT SHEET SERIES 1 (2012) [hereinafter CMS, TELEHEALTH], *available at* <http://www.americantelemed.org/docs/default-source/policy/cms-medicare-telehealth-services-fact-sheet.pdf>, *archived at* <http://perma.cc/Y8ZJ-YX56>; see also AM. TELEMEDICINE ASS'N, TELEMEDICINE AND TELEHEALTH SERVICES 4 (2013), *available at* <http://www.americantelemed.org/docs/default-source/policy/medicare-payment-of-telemedicine-and-telehealth-services.pdf>, *archived at* <http://perma.cc/F9VG-7AJC>; Lois A. Bowers, *Remote Patient-Monitoring Technology Still Faces Reimbursement*

the many other benefits that telehealth has the potential to offer, there are many barriers preventing its widespread use and implementation.⁷

Currently, telehealth is a significant issue at both the state and federal levels.⁸ The current climate of health care reform in the United States and the need for some type of economic relief demands that telehealth be examined as one possible part of a larger solution.⁹ Given national economic distress, high unemployment rates that contribute to a loss of health insurance, and the inability of health care institutions to accommodate this lack of insurance, the time is ripe to implement and utilize the health technology already available to remedy the problem.¹⁰ The implementation of the Affordable Care Act and resulting expansion of health insurance coverage is expected to increase provider shortages, and an increase in chronic diseases combined with an aging population further demonstrate the need for telehealth.¹¹ In today's society, the use of communications technology in everyday life is enormous, and the development of new and promising information communications technologies shows that the nation may be ready for its integration into health care.¹² Problems of access, quality, and the cost of health care services can all be partially alleviated by telehealth.¹³

In multiple reports, the Department of Health and Human Services and the Department of Commerce, along with other federal agencies and private and public organizations, identified physician licensure as a major barrier to the progression of telehealth.¹⁴ The current regulatory structure in place has not

Roadblock, LONG-TERM LIVING (Aug. 15, 2013), <http://www.itlmagazine.com/article/remote-patient-monitoring-technology-still-faces-reimbursement-roadblock>, archived at <http://perma.cc/F8GD-35JH>.

⁷ Impediments include legal issues concerning licensure, accreditation, credentialing, privileging, malpractice, document security, fraud, and intellectual property rights. Paul Spradley, Comment, *Telemedicine: The Law Is the Limit*, 14 TUL. J. TECH. & INTELL. PROP. 307, 309 (2011).

⁸ See generally Carl F. Ameringer, *State-Based Licensure of Telemedicine: The Need for Uniformity but Not a National Scheme*, 14 J. HEALTH CARE L. & POL'Y 55 (2011).

⁹ Spradley, *supra* note 7, at 330–33.

¹⁰ Rashid L. Bashshur & Gary W. Shannon et al., *National Telemedicine Initiatives: Essential to Healthcare Reform*, 15 TELEMEDICINE & E-HEALTH 600, 601 (2009).

¹¹ HEALTH POLICY INST. OF OHIO, LOOKING AHEAD: UNDERSTANDING TELEHEALTH IN OHIO 15 (2013) [hereinafter HPIO, LOOKING AHEAD], available at http://a5e8c023c8899218225edfa4b02e4d9734e01a28.gripelements.com/pdf/publications/hpio_telehealth_brief.pdf, archived at <http://perma.cc/X2CY-B49H>.

¹² See Bashshur & Shannon et al., *supra* note 10, at 602 (stating that the development of new technologies has created pressures for changes in health care, an example being websites that provide health care information to consumers and professionals instantaneously).

¹³ Diane Hoffman & Virginia Rowthorn, *Legal Impediments to the Diffusion of Telemedicine*, 14 J. HEALTH CARE L. & POL'Y 1, 2 (2011).

¹⁴ MARY K. WAKEFIELD, U.S. DEP'T OF HEALTH & HUMAN SERVS. HEALTH RES. & SERVS. ADMIN., HEALTH LICENSING BOARD REPORT TO CONGRESS 5 (2010), available at

grown to encompass the novel legal issues raised by telehealth practices.¹⁵ The legal framework surrounding physician licensure developed when health care was strictly a local industry, and remote provision of health care services was not even a possibility.¹⁶ In order to improve the efficiency and effectiveness of electronic practice services, and to address the increasing shortages of health care professionals, the United States must implement a different system for physician licensure in regards to telehealth that simplifies the process of obtaining the requisite licensure.¹⁷

This Note examines the substantial benefits that telehealth can provide to the health care system of the United States and suggests that the federal government adopt a federal telehealth licensing program, separate from general physician licensure, to facilitate the interstate practice of telehealth. Part II describes the current climate of health care in the United States, first through an internal examination, and then by comparing costs and quality with other countries. Part II then defines telehealth and describes the benefits that it can have on the health care system, including examples of cases in which these benefits have been realized. Part III examines current regulations and barriers to expanding the use of telehealth first by looking at state regulation and then by scrutinizing federal regulations including the Affordable Care Act and the Medicare and Medicaid systems. Part III will identify which statutes and regulations create barriers to telehealth and which ones are conducive to its adoption. Part IV establishes a framework for a national telehealth licensure system for physicians that the federal government should implement and explains that the system is constitutional under the Commerce and Spending Clauses.

II. BACKGROUND AND BENEFITS OF TELEHEALTH

The current climate of the health care system in the United States establishes the need for regulations that cultivate the growth of telehealth services.¹⁸ After examining the United States health care system and comparing it to other industrialized nations, the need for telehealth to help remedy an apparent disparity in cost and outcomes can be realized. An

<http://www.hrsa.gov/ruralhealth/about/telehealth/licenserpt10.pdf>, archived at <http://perma.cc/D7WY-TYKQ>.

¹⁵Hoffman & Rowthorn, *supra* note 13, at 5; see also Meghan Hamilton-Piercy, *Cybersurgery: Why the United States Should Embrace This Emerging Technology*, 7 J. HIGH TECH. L. 203, 206 (2007) (explaining that despite growth in the medical field telehealth faces many challenges in the legal field).

¹⁶Hoffman & Rowthorn, *supra* note 13, at 5.

¹⁷MARY K. WAKEFIELD, U.S. DEP'T OF HEALTH & HUMAN SERVS. HEALTH RES. & SERVS. ADMIN., SPECIAL REPORT TO THE SENATE APPROPRIATIONS COMMITTEE: TELEHEALTH LICENSURE REPORT 6 (2010), available at <http://www.hrsa.gov/healthit/telehealth/licenserpt10.pdf>, archived at <http://perma.cc/HJ8U-YMM9>.

¹⁸See generally Bashshur & Shannon et al., *supra* note 10.

explanation of what telehealth encompasses, and an examination of the possible services available through the emerging technology demonstrates that telehealth can remedy some of the specific problems plaguing the United States' health care system today.

A. The Current Climate of Health Care in the United States

The health care system of the United States is currently in a state of disarray.¹⁹ While new policies and regulations aim to lower costs and relieve disparities regarding access, the numbers imply that there is no single solution to the problem, and political hurdles make progress uncertain.²⁰ The health care crisis facing the United States is apparent, and the amount of attention dedicated to it by the media and politicians demonstrates the urgency of the problem.²¹ Currently, government expenditures on health care surpass spending on all other government services including national defense, education, and pensions.²² While this is the case, 20% of Americans live in an area that has a shortage of primary care physicians, and this shortage is expected to increase.²³ Three factors that play a major role in causing this crisis are (1) an inefficient and outdated health care delivery system; (2) a high prevalence of medical errors; and (3) the unaffordable price of health care, made worse by an intricate and complex payment system.²⁴ Telehealth can play a role in alleviating each of these factors.

¹⁹ Kenneth Shuster, *Because of History, Philosophy, the Constitution, Fairness & Need: Why Americans Have a Right to National Health Care*, 10 IND. HEALTH L. REV. 75, 82 (2013) (stating that many presidents, including President Obama, have explored "various avenues to remedy our present health care crisis").

²⁰ See Janet L. Dolgin & Katherine R. Dieterich, *Social and Legal Debate About the Affordable Care Act*, 80 UMKC L. REV. 45, 45 (2011) (discussing political hurdles and backlash concerning the Affordable Care Act, including efforts by Congress to repeal the Act, or parts of it, and concessions by the Obama administration).

²¹ Lawrence O. Gostin et al., *Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population's Well-Being*, 159 U. PA. L. REV. 1777, 1778 (2011) ("It is hard to overstate the intense political and media attention given to health care.").

²² Amar Gupta & Deth Sao, *The Constitutionality of Current Legal Barriers to Telemedicine in the United States: Analysis and Future Directions of Its Relationship to National and International Health Care Reform*, 21 HEALTH MATRIX 385, 390 (2011); see also Gostin et al., *supra* note 21, at 1778 (stating that the United States as a whole spends more money on health care than on "subsistence goods").

²³ Amy E. Zilis, Note, *The Doctor Will Skype You Now: How Changing Physician Licensure Requirements Would Clear the Way for Telemedicine to Achieve the Goals of the Affordable Care Act*, 2012 U. ILL. J.L. TECH. & POL'Y 193, 194.

²⁴ John W. Hill et al., *Law and the Healthcare Crisis: The Impact of Medical Malpractice and Payment Systems on Physician Compensation and Workload As Antecedents of Physician Shortages—Analysis, Implications, and Reform Solutions*, 2010 U. ILL. J.L. TECH & POL'Y 91, 93.

Over the past fifty years, the percentage of the gross domestic product (GDP) dedicated to health spending in the United States has increased substantially, without a coordinate increase in quality of health care.²⁵ In 2013, the United States spent \$2.9 trillion on health care, and this number is only increasing.²⁶ This trend is particularly glaring when measured with respect to GDP; in 2013, health spending made up 18% of GDP, whereas in 2000, it constituted 14%, and in 1960, it constituted 5%.²⁷ Based on current projections, the United States will spend 21% of its GDP on health care in 2023.²⁸ This projected increase is particularly alarming considering that the growth significantly exceeds both GDP growth and real earnings in the United States.²⁹

If other industrialized countries comparable to the United States spent relatively similar amounts of money on health care, perhaps the situation would not seem as dire. However, this is not the case, as the United States substantially outspends all other countries on health care year after year, both in terms of per capita spending and as a percentage of GDP.³⁰ On average, health care spending in the United States is twice as much per capita, and 50% more as a share of GDP, as compared to other industrialized countries.³¹ A report prepared by the Organization for Economic Cooperation and Development (OECD) comparing health care spending across twelve industrialized nations demonstrates this disparity.³² In 2008, the United States spent \$7,538 per capita on health care while the median per capita spending on health care in other countries was markedly less than half of that at \$2,995.³³ The next highest spending country per capita on health care was Norway, spending \$5,003.³⁴ The fact that the United States spends over \$2,500 more per capita on health care than the next highest spending country is concerning.

²⁵ THE COMMONWEALTH FUND, CONFRONTING COSTS: STABILIZING U.S. HEALTH SPENDING WHILE MOVING TOWARD A HIGH PERFORMANCE HEALTH CARE SYSTEM 7 (2013), available at http://www.commonwealthfund.org/~media/files/publications/fund-report/2013/jan/1653_commission_confronting_costs_web_final.pdf, archived at <http://perma.cc/95JG-JAXE>.

²⁶ CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES 2013 HIGHLIGHTS (2014), available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>, archived at <http://perma.cc/4E89-RND2>.

²⁷ THE COMMONWEALTH FUND, *supra* note 25, at 7.

²⁸ *Id.*

²⁹ Susan Adler Channick, *Health Care Cost Containment: No Longer an Option but a Mandate*, 13 NEV. L.J. 792, 801 (2013) (explaining that the best hope for both the private and public payment sectors is cutting the per capita cost of providing care).

³⁰ David A. Squires, *The U.S. Health System in Perspective: A Comparison of Twelve Industrialized Nations*, 16 COMMONWEALTH FUND 1, 2 (2011).

³¹ THE COMMONWEALTH FUND, *supra* note 25, at 7.

³² Squires, *supra* note 30, at 2.

³³ *Id.*

³⁴ *Id.*

This concern is exacerbated by the fact that despite spending considerably more than other countries on health care, the United States does not produce better health outcomes.³⁵ A study examining seven industrialized nations concluded that the United States ranks last or next to last on all five dimensions of a high performance health system: quality, access, efficiency, equity, and long, healthy, and productive lives.³⁶ Despite spending more on health care, Americans had fewer physician visits than most countries, lower hospital admission rates, and shorter hospital stays, but spent almost three times more than the median amount per hospital discharge (\$16,708 compared to the median \$5,949).³⁷ The United States has a relatively young population and the incidence of chronic disease is average compared with other industrialized countries, discrediting explanations often given for the disparity between cost and outcome.³⁸ The high cost of medical care and services in the United States is a more viable explanation.³⁹

Given the amount of money that the United States spends on health care, especially when considering how much other industrialized countries spend while achieving similar or better results, legislatures and regulators must examine new possibilities for lowering the cost of health care, while improving quality and efficiency. Telehealth is one such possibility.⁴⁰

B. What Is Telehealth?

Telehealth is a method of providing health care services that increases the contact between a patient and the medical system without requiring physical

³⁵ KAREN DAVIS ET AL., THE COMMONWEALTH FUND, MIRROR, MIRROR ON THE WALL: HOW THE PERFORMANCE OF THE U.S. HEALTH CARE SYSTEM COMPARES INTERNATIONALLY: 2010 UPDATE 1 (2010), *available at* http://www.commonwealthfund.org/~media/files/publications/fund-report/2010/jun/1400_davis_mirror_mirror_on_the_wall_2010.pdf, *archived at* <http://perma.cc/56UL-YDTU>.

³⁶ *Id.* at 3 (comparing the United States health care system with the health care systems of Australia, Canada, Germany, New Zealand, the Netherlands, and the United Kingdom based on factors determined by the Commonwealth Fund's Commission on a High Performance Health System).

³⁷ Squires, *supra* note 30, at 4.

³⁸ *Id.* at 11 (explaining that studies have explored the possibility that factors including "administrative complexity, the aging of the population, the practice of 'defensive medicine' under threat of malpractice litigation, chronic disease burden, health care supply and utilization rates, access to care, resource allocation, and the use of technologically advanced equipment and procedures" are responsible for the price disparity, and that the studies have found these factors are not substantial).

³⁹ Gupta & Sao, *supra* note 22, at 390. Squires suggests that along with higher prices, major reasons for the disparity between price and outcome include a more fragmented care delivery system that causes duplication of resources and widespread utilization of specialists that are poorly coordinated. Squires, *supra* note 30, at 11.

⁴⁰ Hoffman & Rowthorn, *supra* note 13, at 2.

contact.⁴¹ Generally, telehealth is “the use of technology to deliver health care, health information or health education at a distance.”⁴² There is no absolute definition of telehealth, and scholars, policy makers, and practitioners assign different meanings to what the term entails.⁴³ Organizations sometimes use the terms telehealth and telemedicine interchangeably, but telehealth is usually classified as broader in scope than telemedicine, with telemedicine only encompassing clinical services provided directly by a practitioner to a patient through electronic communications.⁴⁴

There are two general types of telehealth services: store-and-forward and real time communication.⁴⁵ Store-and-forward, or asynchronous communication, refers to services that transmit medical data, including clinical information and images, to a practitioner for later assessment.⁴⁶ The sender and receiver are not required to communicate with each other at the same time.⁴⁷ Practitioners typically use store-and-forward services for diagnosis and treatment decisions.⁴⁸ These services include the transmission of x-rays, echocardiograms, and other radiographic images.⁴⁹ Asynchronous communication also includes remote monitoring, where providers can observe diagnostic indicators such as blood pressure and insulin levels without requiring patients to leave their homes.⁵⁰ This monitoring can be useful in the management of chronic diseases.⁵¹

Real time, or synchronous communication, refers to communication that is instantaneous, and includes the use of interactive telecommunications devices such as audio and video equipment.⁵² This may include video conferences between a patient and a specialist, where the specialist is consulting with the patient and his practitioner about treatment, or video conferences between

⁴¹ *What Is Telehealth?*, U.S. DEP’T OF HEALTH & HUM. SERVS., <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Telehealth/whatistelehealth.html> (last visited Feb. 15, 2015) [hereinafter HRSA, *Telehealth*], archived at <http://perma.cc/X7N4-XTWZ>.

⁴² *Id.*

⁴³ HPIO, LOOKING AHEAD, *supra* note 11, at 1.

⁴⁴ *Id.* (explaining how the CMS’s definition of telemedicine is more narrow than the World Health Organization’s definition).

⁴⁵ Hoffman & Rowthorn, *supra* note 13, at 2.

⁴⁶ HPIO, LOOKING AHEAD, *supra* note 11, at 1.

⁴⁷ See Victoria A. Wade et al., *A Systematic Review of Economic Analyses of Telehealth Services Using Real Time Video Communication*, 10 BMC HEALTH SERVS. RES. 1, 2 (2010) (explaining that store-and-forward communications are collected, transmitted, and then utilized at a later time).

⁴⁸ Spradley, *supra* note 7, at 311 (pointing out that store-and-forward communications have been used for outsourcing medical data to specialists for many years).

⁴⁹ HPIO, LOOKING AHEAD, *supra* note 11, at 2. This method of providing services can be especially helpful in specialty practice areas such as dermatology, radiology, and pathology. Hoffman & Rowthorn, *supra* note 13, at 3.

⁵⁰ HPIO, LOOKING AHEAD, *supra* note 11, at 2.

⁵¹ Spradley, *supra* note 7, at 312.

⁵² Hoffman & Rowthorn, *supra* note 13, at 3.

specialists and internists, where the specialist is teaching the interns about a new or special procedure or treatment.⁵³ Real time communication services can be especially helpful to patients in rural areas, where access to specialists and emergency care is limited.⁵⁴

Effective treatment plans may include a hybrid of both of these categories of telehealth, and some services may not expressly fall under either. For example, educational programming aimed at children for preventative care,⁵⁵ electronic prescribing of medication, and mobile phone applications that engage patients in their treatment plans,⁵⁶ are not strictly real-time or store-and-forward services. The distinction may not matter in the future if telehealth is widely used and implemented, but current reimbursement issues involving the private sector, state law, and Medicare and Medicaid services make the distinction relevant.⁵⁷

C. The Potential Benefits of Telehealth on the Health Care System of the United States

Given the current climate of the health care system in the United States, there is much room for improvement. Telehealth can help alleviate problems facing health care providers, payers, and policy makers. Telehealth has the potential to improve quality, efficiency, cost, and access to care.⁵⁸ Some specific problems that telehealth has the potential to ease include: (1) inequity in access to care resulting from geographic, socioeconomic, and cultural disparities; (2) inefficiencies in the coordination and integration of complex systems of health care; (3) and an uneven distribution in quality of care resulting from a high frequency of medical errors, deviation from evidence-

⁵³ HRSA, *Telehealth*, *supra* note 41.

⁵⁴ JOSHUA EWING, NAT'L CONFERENCE OF STATE LEGISLATURES (NCSL), TELEHEALTH AND RURAL HEALTHCARE DELIVERY 1 (2011), *available at* <http://www.ncsl.org/Portals/1/documents/health/RHTelehealth.pdf>, *archived at* <http://perma.cc/J8QF-GEZ5>.

⁵⁵ Bashshur & Shannon et al., *supra* note 10, at 605.

⁵⁶ HPIO, LOOKING AHEAD, *supra* note 11, at 2.

⁵⁷ See *infra* Part III.A.2 (explaining that states differ as to what they will reimburse for under the federal programs, and that these differences are categorized in reference to the kind of telehealth communication utilized).

⁵⁸ Bradley J. Kaspar, Note, *Legislating for a New Age in Medicine: Defining the Telemedicine Standard of Care to Improve Healthcare in Iowa*, 99 IOWA L. REV. 839, 857 (2014) (explaining that telehealth can slow the rising cost of health care and that the potential for this increases over time because the costs of telehealth technology have consistently and substantially declined). One expert "boldly" claims that the United States could realize a 90% decrease in health care costs by utilizing telehealth as it is used in India. *Id.* (citing Vijay Govindarajan, *Telemedicine Can Cut Health Care Costs by 90%*, HARV. BUS. REV. (Apr. 23, 2012, 11:42 AM), <http://blogs.hbr.org/2012/04/how-telemedicine-saves-lives-a/>, *archived at* <http://perma.cc/MW7J-PS5A>).

based medicine, and the prevalence of unhealthy lifestyles.⁵⁹ Telehealth has the potential to improve access to all levels of health care, support patient-centered care at a lower cost in local environments, increase the efficacy of both in-home and facility provided chronic disease management, and promote efficiency in clinical decision-making and prescribing medication.⁶⁰

One of the most apparent problems that telehealth can help lessen is a lack of access to health care. Populations that include persons in correctional facilities, those in need of home health care, and persons residing in rural areas can all benefit from the utilization of telehealth services.⁶¹ Currently, rural areas are experiencing a major shortage of primary care physicians and an even greater shortage of specialists.⁶² While 20% of Americans live in rural areas, only 9% of physicians practice in these areas.⁶³ Persons living in rural areas are twice as likely to die from unintentional injuries than people in urban areas, and half of all car accident deaths occur in rural areas, even though only about a quarter of the population lives there.⁶⁴ This can be largely attributed to the distance people have to drive for care and the lack of practitioners and specialists available for emergency care.⁶⁵ Even with the implementation of the Affordable Care Act and its provisions aimed at addressing provider shortages, practitioners will still be less likely to practice in rural areas.⁶⁶

Telehealth can help remedy this problem by facilitating treatment from a distance. Physicians can conduct real-time examinations through video conferencing at interactive television and emergency centers, and physicians in rural areas can connect to specialists for consultation when there is not one available on site.⁶⁷ For example, a private medical group, Avera, provides telehealth services such as eEmergency, eICU, eStroke, and eConsult, which connect patients and physicians in rural areas to specialty physicians.⁶⁸ The eEmergency service connects rural emergency rooms to physicians and specialists at a central hub, so that the physicians at the hub can help guide and

⁵⁹ Bashshur & Shannon et al., *supra* note 10, at 602.

⁶⁰ *Id.* at 601.

⁶¹ Gupta & Sao, *supra* note 22, at 390.

⁶² *Id.*

⁶³ Lynne Holt & Mary Galligan, *State and Federal Policies to Accelerate Broadband Deployment: A Policy Checklist*, 17 COMMLAW CONSPECTUS 141, 155 (2008).

⁶⁴ EWING, *supra* note 54, at 1; Gupta & Sao, *supra* note 22, at 391.

⁶⁵ Gupta & Sao, *supra* note 22, at 390.

⁶⁶ EWING, *supra* note 54, at 1.

⁶⁷ Gupta & Sao, *supra* note 22, at 391. Another example involves cybersurgery, where a surgeon uses a control panel to perform a surgical procedure by connecting with and controlling a medical device from a distance. Hamilton-Piercy, *supra* note 15, at 204. This technology, which has already been developed and utilized successfully in other countries such as Canada, could allow rural areas to connect patients to qualified specialists they otherwise would not have access to. *Id.* at 204 & n.2.

⁶⁸ EWING, *supra* note 54, at 1.

support emergency care in order to stabilize patients.⁶⁹ Studies have shown that telehealth services decrease the amount of time rural patients have to wait for specialty care, reduce mortality and length of stay for patients using an eICU, and decrease hospital admissions and length of stay when home telehealth services are implemented for patients with chronic conditions.⁷⁰ This in turn can help lower costs.

The combination of store-and-forward and real-time communication usage in emergency rooms, prisons, nursing home facilities, and physician offices could save the United States \$4.28 billion on health care spending per year, according to a study by the Center for Information Technology Leadership.⁷¹ This study found that the potential benefits of telehealth outweighed the cost of implementation.⁷² A specific example regarding inmate care in California demonstrated that in 2004, prison officials provided around 9,000 telehealth consultations, saving taxpayers more than \$4 million in transportation and escort costs alone, and reducing the security risks involved with such transport.⁷³ Additionally, studies have shown that the implementation of telepsychiatry results in a reduction of violent acts in correctional facilities.⁷⁴ By expanding telehealth to prisons alone, taxpayers could save hundreds of millions of dollars a year. It is not hard to see how the mentioned examples could transfer on a larger scale to help society as a whole.

III. CURRENT REGULATIONS AND BARRIERS

While the states substantially regulate the use of telehealth, there are still ways that the federal government can help or hinder telehealth's growth and application through incentives and reimbursement policies. The federal government's limited role in telehealth regulation means that each state can impose its own statutory framework, and this has not been conducive to the

⁶⁹ *Id.* ("The eEmergency service 'links two-way video equipment in local rural emergency rooms to emergency-trained physicians and specialists at a central hub, 24 hours a day, seven days a week' in order to provide support, consultation or initiate physician-guided emergency care until a doctor can arrive on scene.").

⁷⁰ *Id.*; HPIO, LOOKING AHEAD, *supra* note 11, at 3.

⁷¹ HPIO, LOOKING AHEAD, *supra* note 11, at 3.

⁷² *Id.* (explaining that although it is difficult to measure the exact value of telehealth, a "large body of research" shows that telehealth can decrease costs, improve outcomes, and increase access to health care).

⁷³ *Telehealth Facts*, CAL. TELEHEALTH RESOURCE CENTER, <http://www.caltrc.org/telehealth/telehealth-facts/> (last visited Jan. 16, 2015), *archived at* <http://perma.cc/7A8A-CVDW>.

⁷⁴ CTR. FOR INFO. TECH. LEADERSHIP, THE VALUE OF PROVIDER-TO-PROVIDER TELEHEALTH TECHNOLOGIES 69 (2007), *available at* <http://telehealth.utmb.edu/presentations/CITL%20-%202007%20-%20The%20Value%20of%20Provider-to-Provider%20Telehealth%20Technologies.pdf>, *archived at* <http://perma.cc/WY9E-M85A>.

interstate nature of telehealth practices.⁷⁵ State regulation of telehealth varies greatly from state to state, and this variation is one of the major impediments preventing its widespread implementation.⁷⁶ The federal government has paid substantial attention to this issue in recent years through funding and policy changes, but there are still many impediments that governments must address at both the state and federal level.⁷⁷

A. State Regulation and Coverage

The biggest barrier preventing the widespread implementation of telehealth services in the United States is the fact that states regulate the practice of medicine within their own boundaries.⁷⁸ Despite the crucial need for telehealth in the medical industry, many states have erected or maintained barriers to its implementation.⁷⁹ Laws dealing with malpractice, privacy, licensure, and insurance reimbursement prevent the use of telehealth from growing.⁸⁰

The Tenth Amendment of the Constitution of the United States grants states the police power to regulate the practice of medical care.⁸¹ This police power allows states to individually regulate activities that affect the health, safety, and welfare of the citizens within their borders, and telehealth presumably fits into this category.⁸² On the other hand, scholars have argued

⁷⁵ Hoffman & Rowthorn, *supra* note 13, at 9–10 (highlighting the administrative burden and uncertainty caused by a “patchwork” of state laws relating to telehealth). Where the federal government does regulate, it usually does not preempt state laws, and allows states to require more stringent standards. Gupta & Sao, *supra* note 22, at 393.

⁷⁶ Gupta & Sao, *supra* note 22, at 392 (“The present and potential uses of telemedicine are constrained by overlapping and often inconsistent and inadequate regulatory frameworks and technical standards imposed by governments and professional medical organizations.”).

⁷⁷ Hoffman & Rowthorn, *supra* note 13, at 7.

⁷⁸ *Id.* at 8–9; *see also* Gupta & Sao, *supra* note 22, at 392 (explaining that because states overlook the “interstate and global nature” of telehealth, they impose regulations that are improperly shaped around medical provisions and practices on a local level).

⁷⁹ Gupta & Sao, *supra* note 22, at 423 (stating that state regulations surrounding licensure, insurance, and information privacy create barriers so challenging to overcome that providers are discouraged from engaging in interstate telehealth practices); Hoffman & Rowthorn, *supra* note 13, at 10 n.55 (explaining that some states have tightened their laws in order to require that anyone practicing medicine in their state have a full medical license from that state, making it more difficult for telehealth practitioners to practice there).

⁸⁰ Gupta & Sao, *supra* note 22, at 393; Susan E. Volkert, *Telemedicine: RX for the Future of Health Care*, 6 MICH. TELECOMM. & TECH. L. REV. 147, 156 (2000) (“[B]arriers include reimbursement limitations and uncertain funding, cumbersome credentialing requirements, legal liability uncertainties and malpractice exposure, unclear data on cost-effectiveness, and a lack of uniform national practice standards and telemedicine standards.” (footnote omitted)).

⁸¹ WAKEFIELD, *supra* note 14, at 6.

⁸² *Id.*

that the Commerce Clause of the Constitution limits the states' police power in relation to telehealth because of the interstate issues involved with technology.⁸³ This tension between the Tenth Amendment and Congress's power under the Commerce Clause is explored in depth later in this Note following a proposal for federal intervention into telehealth regulation.⁸⁴ Currently, the problems facing the implementation of telehealth services are substantially addressed and caused by the states.

1. *Physician Licensure*

One of the more controversial topics that come up in this context is physician licensure. In multiple reports, the Department of Health and Human Services and the Department of Commerce, along with other federal agencies and private and public organizations, identified licensure as a major barrier to the progression of telehealth.⁸⁵ Physician licensure is granted state-by-state, and generally, for a doctor to practice in more than one state she must go through the costly and time-consuming process of applying for licensure in each state where she wants to practice.⁸⁶

Basic standards for licensure are largely the same, but there are different filing and administrative requirements that make it difficult for physicians to establish multiple state licenses.⁸⁷ State licensure fees create a disincentive for a physician to obtain multiple state licenses given that a physician may have to pay the fee in every state that she wishes to obtain licensure.⁸⁸ This can be extremely costly depending on the state. For example, obtaining a medical license in California requires a licensing fee of \$805, with an additional application fee of \$493, while in Alaska, the application fee is *only* \$200, and

⁸³ Gupta & Sao, *supra* note 22, at 415–32. In addition to the Commerce Clause, the Spending Clause also presents a viable route for federal regulation. *See infra* sources cited note 179.

⁸⁴ *See infra* Part IV.B.

⁸⁵ WAKEFIELD, *supra* note 17, at 6. There are seventy-one different licensing jurisdictions in the United States and its territories that set forth requirements for physician licensure. *Directory of State Medical and Osteopathic Boards*, FED'N OF ST. MED. BOARDS, http://www.fsmb.org/directory_smb.html (last visited Jan. 16, 2015), *archived at* <http://perma.cc/YA78-SHJE>. The fact that there are seventy-one different licensing jurisdictions reveals the problem of inconsistent requirements.

⁸⁶ Michael S. Young & Rachel K. Alexander, *Recognizing the Nature of American Medical Practice: An Argument for Adopting Federal Medical Licensure*, 13 DEPAUL J. HEALTH CARE L. 145, 166 (2010).

⁸⁷ WAKEFIELD, *supra* note 17, at 9. Every licensure authority “must ensure that those entering the profession are academically qualified, competent, and mentally and physically fit to provide the activities covered by the license.” *Id.*

⁸⁸ Young & Alexander, *supra* note 86, at 176.

the licensure fee is \$300.⁸⁹ This financial burden is compounded by the fact that states require licenses to be renewed, sometimes annually.⁹⁰ Other requirements that vary state-to-state include fingerprinting, criminal background checks, Continuing Medical Education (CME) hours, licensing exams, and limits on the number of times a person may attempt to pass licensing exams.⁹¹ These time-consuming production requirements and financial burdens have the effect of discouraging physicians from obtaining multiple licenses.⁹²

While some states have implemented regulations that are conducive to the practice of telehealth across state lines, others have enforced stricter regulations, requiring full state licensure of any physician practicing in the state, regardless of the circumstances.⁹³ State concerns related to recognizing the licenses of other states include loss of revenue from the licensure process, protecting state health care markets from outside competition, loss of control or authority over licensing requirements that a state deems indispensable, and loss of control over standards of care and disciplinary actions.⁹⁴ For example, some state medical boards require physicians to complete fifty mandatory CME hours a year, while others do not require them at all.⁹⁵ A state that does require CME will be reluctant to allow a physician to practice telehealth in that state when her license does not carry such a mandate. These concerns have hindered the practice of telehealth over state lines.⁹⁶

Some states, however, have come up with and adopted alternative licensure models that allow physicians to practice across state lines using telehealth services. For example, sixteen states have adopted a system that grants special purpose licenses to out-of-state practitioners wishing to practice telehealth in those states.⁹⁷ The Federation of State Medical Boards (FSMB) suggested this model in 1996, as *A Model Act to Regulate the Practice of*

⁸⁹ *State-Specific Requirements for Initial Medical Licensure*, FED’N OF ST. MED. BOARDS, http://www.fsmb.org/usmle_eliinitial.html (last updated Nov. 2013), *archived at* <http://perma.cc/3L69-PSDL>.

⁹⁰ Young & Alexander, *supra* note 86, at 175.

⁹¹ *Id.* at 172. Requirements that are the same in every state include the requirement that a physician graduate from a nationally approved educational program. WAKEFIELD, *supra* note 17, at 9. In addition, in order to obtain licensure a physician must pass all three tests of the United States Medical Licensing Exam, which are the same in every state. Spradley, *supra* note 7, at 319.

⁹² Twenty-two percent of licensed physicians have licenses in multiple states, and may have gone through the “onerous” process of initial licensure for each state. WAKEFIELD, *supra* note 14, at 25.

⁹³ Hoffman & Rowthorn, *supra* note 13, at 10.

⁹⁴ WAKEFIELD, *supra* note 17, at 21.

⁹⁵ Young & Alexander, *supra* note 86, at 175.

⁹⁶ *See generally* Ameringer, *supra* note 8.

⁹⁷ WAKEFIELD, *supra* note 14, at 17.

Medicine Across State Lines.⁹⁸ Under this framework, the requirements for obtaining limited licenses are relaxed compared to the requirement of full state licensure.⁹⁹ While this is the case, the special purpose licenses differ by state, with some states only allowing physicians to conduct physician-to-physician consultations in a certain practice area, and other states allowing physician-to-patient telehealth consultations.¹⁰⁰ Other states embrace a system of endorsement, where state boards grant licenses to health professionals from other states. However, these state boards may require additional documentation or qualifications and may require the physician to apply for such licensure, all of which discourages physicians from applying.¹⁰¹

Other states such as South Dakota have reciprocity statutes that form a compact between states with similar or identical licensing requirements.¹⁰² A system based on reciprocity does not require a physician to submit to further review of individual credentials; states party to the agreement automatically recognize each other's licenses.¹⁰³ The Nurse Licensure Compact (NLC) model, first implemented in 2000, is an example of a licensure model based on reciprocity.¹⁰⁴ The NLC allows a nurse with a valid license to practice in other states party to the compact, both in person and through telecommunications technology, subject to the other states' practice laws and discipline.¹⁰⁵ While

⁹⁸ See generally FED'N OF STATE MED. BDS. OF THE U.S., REPORT OF THE AD HOC COMMITTEE ON TELEMEDICINE: A MODEL ACT TO REGULATE THE PRACTICE OF MEDICINE ACROSS STATE LINES (1996), available at http://library.fsmb.org/pdf/1996_grpol_Telemedicine.pdf, archived at <http://perma.cc/2MSM-XWJM>.

⁹⁹ Young & Alexander, *supra* note 86, at 173–74. (explaining that some states like Minnesota only require proof of a current state license from any state, a \$75 annual fee, and verification that the physician has not had a license revoked in any state to qualify for a special purpose license); Zilis, *supra* note 23, at 210 (explaining that generally states granting limited licenses require physicians to pay the same fee as required for a full license).

¹⁰⁰ Hoffman & Rowthorn, *supra* note 13, at 17; see also Gupta & Sao, *supra* note 22, at 396 (“This cautious approach towards implementation and deference to state authority indicates that the FSMB proposal primarily represents states’ interests, and not necessarily what is the most optimal approach in facilitating the practice of telemedicine.”).

¹⁰¹ WAKEFIELD, *supra* note 17, at 10 (stating that endorsement allows states to retain the power to set and enforce standards for licensure, but complying with such standards can still be “time consuming and expensive for a multi-state practitioner”).

¹⁰² Young & Alexander, *supra* note 86, at 172.

¹⁰³ WAKEFIELD, *supra* note 17, at 10 (explaining that negotiations can be multilateral or bilateral, and that “[a] license valid in one state would give privileges to practice in all other states with which the home state has agreements”).

¹⁰⁴ Ross D. Silverman, *Regulating Medical Practice in the Cyber Age: Issues and Challenges for State Medical Boards*, 26 AM. J. L. & MED. 255, 269 (2000).

¹⁰⁵ *Id.*; WAKEFIELD, *supra* note 17, at 18. Nursys, a coordinate licensure information system, requires states to report disciplinary actions to the database and all states party to the compact have access to the system, but only the nurse’s home state can take direct action on her anchor license. *Id.* at 19–20.

this may seem like a workable model for physician licensure,¹⁰⁶ the slow rate of adoption among the states prevents the model from significantly affecting licensure portability.¹⁰⁷ In 2000, eight states were party to the compact;¹⁰⁸ fourteen years later only sixteen more have joined.¹⁰⁹ This demonstrates the insufficiency of such a model.¹¹⁰

While these alternative models are a step in the right direction, more states need to implement them for telehealth to reach its full potential. The likelihood that every state will agree to a single licensing structure is highly unlikely however,¹¹¹ so the time is ripe for federal intervention.

The historical justifications for state based physician licensure are outdated and no longer relevant.¹¹² The issues surrounding health and safety in the context of licensure do not have “local peculiarities,”¹¹³ and recent developments in technology and medical knowledge remove the exclusivity of health care as a local concern.¹¹⁴ Although monitoring the quality of care within a state’s boundaries is often the stated reason for state based physician licensure, protection of state’s rights, and the shielding of trade from outside competition are more likely the primary motivating factors.¹¹⁵ A federal licensure system that only regulates the use of telehealth, separate from general physician licensure, would lessen these concerns.

¹⁰⁶ Gil Siegal, *Enabling Globalization of Health Care in the Information Technology Era: Telemedicine and the Medical World Wide Web*, 17 VA. J.L. & TECH. 1, 16–17 (2012) (“[O]ne is left to wonder why [the NLC] has not been adopted in other areas of licensing health-care professionals.”).

¹⁰⁷ WAKEFIELD, *supra* note 17, at 23–25 (explaining that a minimum of thirty to thirty-five states need to join the NLC for its impact to be significant).

¹⁰⁸ Silverman, *supra* note 104, at 270.

¹⁰⁹ *Nurse Licensure Compact*, NAT’L COUNCIL OF ST. BOARDS OF NURSING, <https://www.ncsbn.org/nlc.htm> (last visited Feb. 13, 2015), *archived at* <https://perma.cc/EED5-WTD7>.

¹¹⁰ See WAKEFIELD, *supra* note 17, at 25.

¹¹¹ As a scholar accurately predicted in regards to the NLC in 2000, “getting legislatures and powerful state professional medical organizations to agree to such drastic changes in licensure policies, which may threaten local economic interests, seems unlikely.” Silverman, *supra* note 104, at 270.

¹¹² Gupta & Sao, *supra* note 22, at 406.

¹¹³ *Id.*; Young & Alexander, *supra* note 86, at 145 (“[U]nlike the legal profession, in which lawyers face diverse laws even in related subjects in each state, medical practice remains generally the same in each state.” (footnote omitted)).

¹¹⁴ Gupta & Sao, *supra* note 22, at 406; Young & Alexander, *supra* note 86, at 196 (“State medical licensing was developed in an era of small federal government when there was ubiquitous substandard medical training; however, the federal government is now large and capable of regulating federal medical licensure, while United States medical training is homogeneously meeting national standards.”).

¹¹⁵ Hoffman & Rowthorn, *supra* note 13, at 17–18. Differences in quality between licensing jurisdictions are no longer apparent given that all jurisdictions require physicians to pass the three parts of the United States Medical Licensing Exam. *Id.* at 17; *see also* Spradley, *supra* note 7, at 319 (stating that the core substantive prerequisites for physician licensure are largely the same across jurisdictions, usually with only minor differences).

Physician licensure regulations prevent rural areas from realizing the benefits of telehealth services that can help remedy the problems of access, quality, and cost. Physicians are less likely to offer telehealth services to people in rural areas because of state licensure issues, which often not only fail to give incentives to practitioners engaging in multi-state telehealth practices, but also create costly and time-consuming barriers that discourage such practices.¹¹⁶ The federal government should enact a federal telehealth licensure system to remove these barriers.¹¹⁷

2. Reimbursement for Telehealth Services

Reimbursement is also a significant problem that prevents the United States from realizing the full benefits of telehealth. Medicare and Medicaid allow reimbursement for limited telehealth services, but states choose whether to allow this and can limit the scope of covered services even further.¹¹⁸ In addition, private insurance reimbursement is limited in most states, but there is a slow trend toward requiring private payer reimbursement on the state level.¹¹⁹ Without coverage for telehealth services, many telehealth projects commenced by providers are unsustainable, and the use of telehealth cannot grow if there is no system in place to fund providers.¹²⁰ Patients will not elect to utilize telehealth services if doing so will require them to pay out-of-pocket, especially if their insurance will cover a non-telehealth service, albeit one that may not be as convenient, and in the end is more expensive to the provider.

Most states require some type of coverage for services under Medicaid, but these services may be extremely limited in scope.¹²¹ Unlike for Medicare, there is no federal law that addresses telehealth service reimbursement for Medicaid, so states have great discretion to structure their own plans.¹²² Forty-six state Medicaid programs reimburse for live video, ten reimburse for store-

¹¹⁶ Young & Alexander, *supra* note 86, at 184.

¹¹⁷ The constitutionality of this federal health licensure system will be discussed *infra* Part IV.B.

¹¹⁸ *State Coverage for Telehealth Services*, NAT'L CONF. ST. LEGISLATURES, <http://www.ncsl.org/issues-research/health/state-coverage-for-telehealth-services.aspx> (last updated Jan. 2015) [hereinafter NCSL, *State Coverage*], archived at <http://perma.cc/2FHT-8LCG>.

¹¹⁹ Gupta & Sao, *supra* note 22, at 405.

¹²⁰ HEALTH POLICY INST. OF OHIO, THE HEALTH POLICY INSTITUTE OF OHIO'S TELEHEALTH LEADERSHIP SUMMIT: KEY FINDINGS AND CONSIDERATIONS 4 (2013) [hereinafter HPIO, LEADERSHIP SUMMIT], available at http://a5e8c023c8899218225edfa4b02e4d9734e01a28.gripelements.com/pdf/publications/telehealthsummit_findingsummary_final.pdf, archived at <http://perma.cc/Q57H-X9TP>.

¹²¹ NCSL, *State Coverage*, *supra* note 118 (providing a state-by-state list of the general services covered by each state, with links to additional state information).

¹²² *See id.*

and-forward services, and thirteen reimburse for remote patient monitoring.¹²³ States provide additional requirements under these categories that further limit reimbursement.

Ohio provides a prime example of the limited scope of required reimbursement under Medicaid. Ohio's Medicaid plan only reimburses for certain mental health services provided by certified community mental health centers, and these services must be provided through interactive video conferencing.¹²⁴ Ohio Medicaid also reimburses some certified Ohio Department of Mental Health and Addiction Service providers for limited case management, group counseling, and individual real-time audiovisual communications.¹²⁵ By restricting reimbursement coverage solely to the area of mental health, many citizens cannot obtain services that could greatly improve their quality of life, such as home telehealth services for monitoring chronic diseases.

In contrast, Arizona's Medicaid program provides expansive reimbursement for telehealth services, including some store-and-forward services, and a large list of real-time services.¹²⁶ Arizona's Medicaid fee-for-service program reimburses for services deemed medically necessary that are provided through live video.¹²⁷ The list of reimbursable services is smaller and more specific for managed care services, but such services are conducive to spreading the benefits of telehealth.¹²⁸ For example, Arizona will reimburse for telehealth services provided by a neurologist to a patient in a rural area within three hours of the onset of stroke symptoms for the purpose of determining the appropriate course of treatment.¹²⁹ Although limited, such a provision, which is specifically tailored to providing services to underserved rural areas, shows how states are harnessing telehealth to remedy the health care disparity between rural and urban areas.¹³⁰

¹²³ CTR. FOR CONNECTED HEALTH POLICY, STATE TELEHEALTH POLICIES AND REIMBURSEMENT SCHEDULES, at Key Findings (2014), available at <http://cchpca.org/sites/default/files/uploader/50%20STATE%20MEDICAID%20REPORT%20SEPT%202014.pdf>, archived at <http://perma.cc/5VVM-KUZ8>.

¹²⁴ HPIO, LEADERSHIP SUMMIT, *supra* note 120, at 4.

¹²⁵ *Id.*

¹²⁶ CTR. FOR CONNECTED HEALTH POLICY, *supra* note 123, at Arizona: 1.

¹²⁷ *Id.* These areas include: Cardiology; Dermatology; Endocrinology; Hematology/Oncology; Home Health; Infectious Diseases; Neurology; Obstetrics/Gynecology; Oncology/Radiation; Pain Clinic; Pathology; Surgery follow-up consults; and certain Behavioral Health Services. *Id.* at Arizona: 1–2.

¹²⁸ *Id.* at Arizona: 3.

¹²⁹ *Id.*

¹³⁰ Arizona recently passed legislation that will go into effect in 2015, requiring private payers to provide coverage for live video consultations when treating specific conditions and the originating site is located in a rural region. S.B. 1353, 51st Leg., 1st Sess. at 344 (Ariz. 2015). Conditions covered include trauma, burn, cardiology, infectious diseases, mental health disorders, neurologic diseases including strokes, and dermatology. *Id.* at 345. This further demonstrates Arizona's utilization of telehealth to reach underserved rural

3. Other Legal Impediments to Telehealth on the State Level

While reimbursement and physician licensure are currently the biggest barriers to the expansion of telehealth, the states also need to address issues related to malpractice insurance coverage, legal liability, and patient privacy.¹³¹ Issues relating to medical malpractice claims will force malpractice insurance providers to create new policies that take into consideration the unique nature of telehealth-related claims.¹³² Case law is understandably underdeveloped on the issue of telehealth malpractice, with the majority of cases only addressing claims against physicians prescribing medication over the Internet.¹³³

Issues likely to come up include questions of jurisdiction and choice of law.¹³⁴ For claims arising out of interstate telehealth practice, courts and policy makers will have to decide which state's law will apply, which standard of care will apply, and whether or not there is a different standard of care applicable to telehealth as opposed to direct consultations.¹³⁵ In addition, issues related to privacy of information standards will require further consideration.¹³⁶ The Health Insurance Portability and Accountability Act

populations. Currently, nineteen states require private payers to cover telehealth services. NCSL, *State Coverage*, *supra* note 118.

¹³¹ Gupta & Sao, *supra* note 22, at 397–403.

¹³² Hoffman & Rowthorn, *supra* note 13, at 32; Volkert, *supra* note 80, at 182 (“The uncertainty of its practice, coupled with the fact that care will take place over a distance, may increase the likelihood of malpractice suits.”). Skeptics of telehealth suggest that the distance between a patient and physician, and the use of technology may cause a doctor to miss a symptom they may have seen in a face-to-face appointment. *Id.* These concerns are unfounded and the opposite may be true, but “since telemedicine is new, the risks are unclear, and unclear risks cost more to insure.” *Id.*

¹³³ Hoffman & Rowthorn, *supra* note 13, at 32. The available case law deals with physicians prescribing medications to patients who have only completed online questionnaires, so it is technically classified as cybermedicine, not telehealth. Kaspar, *supra* note 58, at 849.

¹³⁴ CHRISTA M. NATOLI, CTR. FOR TELEHEALTH & E-HEALTH LAW, SUMMARY OF FINDINGS: MALPRACTICE AND TELEMEDICINE 1–2 (2009), *available at* <http://www.ctel.org/research/Summary%20of%20Findings%20Malpractice%20and%20Tel%20medicine.pdf>, *archived at* <http://perma.cc/8DTP-42ZD>. In cases involving medical malpractice and telemedicine, parties should not assume that the laws of the state where the court resides will govern the case. *Id.* at 2. In deciding which state's law will govern the case, a court may analyze factors such as where the event took place and the majority of the parties to the case reside. *Id.* This has not yet come up in case law. *Id.*

¹³⁵ Hoffman & Rowthorn, *supra* note 13, at 33; *see, e.g.*, Kaspar, *supra* note 58, at 853 (explaining that applying a custom-based standard of care, as is the practice in some jurisdictions, would be difficult for telehealth claims because any new application of telehealth services would fall below the standard of care given its modern nature).

¹³⁶ Volkert, *supra* note 80, at 215–16 (“Concerns exist relating to the ready accessibility to electronic patient information, the conveyance of video images, the presence of additional persons, the possible loss of control over the route of medical

(HIPAA) sets federal standards that states must follow, but states are free to impose more stringent security measures.¹³⁷ Without a uniform standard, practitioners may subject themselves to additional liability where they did not even realize there was a problem. These issues among others will undoubtedly arise as telehealth becomes more widely utilized.

B. *Federal Regulation and Coverage*

The federal government plays a limited role in regulating telehealth, and this role is largely constrained to Medicare reimbursement.¹³⁸ While this is the case, the Affordable Care Act and other recent legislation aim to create incentives for states to develop telehealth services and regulations conducive to such services by providing funding and reimbursement incentives.¹³⁹ In addition, legislation has been proposed in an attempt to remedy issues largely thought of as reserved to the states, such as physician licensure, by regulating such issues only in the context of federal programs, bringing the services under federal authority.¹⁴⁰

1. *Medicare and Medicaid Reimbursement for Telehealth*

Federal law does not limit or require states to reimburse for telehealth services through Medicaid, leaving states to determine which services, if any, are eligible for reimbursement.¹⁴¹ The federal government does, however, restrict the types of telehealth services eligible for reimbursement through Medicare as well as the geographic locations where telehealth services can be provided.¹⁴² Medicare regulation remedies certain issues that have yet to be worked out on the state level, such as credentialing and privileging between provider sites.¹⁴³

Medicare will only reimburse for certain services provided via real-time interactive audio and video communications to a Medicare beneficiary that receives such services at an “eligible site.”¹⁴⁴ This narrow category is further

information, the integrity of electronic record keeping, and the potential for unauthorized access and disclosure of records.”).

¹³⁷ Gupta & Sao, *supra* note 22, at 402–03.

¹³⁸ HPIO, LOOKING AHEAD, *supra* note 11, at 5; *see also* Gupta & Sao, *supra* note 22, at 393 (“In the few areas where the federal government does regulate, it often does not preempt state power and allows states to impose stricter standards.”).

¹³⁹ Zilis, *supra* note 23, at 199.

¹⁴⁰ *See* Telehealth Promotion Act of 2012, H.R. 6719, 112th Cong. (2d Sess. 2012); TELEmedicine for MEDicare Act of 2013, H.R. 3077, 113th Cong. (1st Sess. 2013).

¹⁴¹ Gupta & Sao, *supra* note 22, at 404–05.

¹⁴² *Id.* at 404.

¹⁴³ HPIO, LOOKING AHEAD, *supra* note 11, at 5.

¹⁴⁴ *Id.* at 8. Eligible sites include the office of a physician or practitioner, a critical access hospital, a rural health clinic, a federally qualified health center, or a hospital. 42 C.F.R. § 410.78(b)(3) (2014).

limited by the provision that the sites must be geographically located in a rural Health Professional Shortage Area, a non-metropolitan statistical area, or be part of a federal telemedicine project.¹⁴⁵ Currently, Medicare does not reimburse for telehealth services that patients receive in their home.¹⁴⁶ Medicare only reimburses for services furnished through asynchronous store-and-forward technology in federal telehealth demonstration programs in Alaska and Hawaii.¹⁴⁷

Significantly, Medicare provides a procedure that alleviates problems hospitals face regarding privileging and credentialing, as required by the Centers for Medicare and Medicaid (CMS) and the Joint Commission.¹⁴⁸ For Medicare reimbursement of telehealth services hospitals can rely upon credentialing and privileging decisions made by distant site hospitals.¹⁴⁹ The receiving hospital must ensure that the hospital providing the services is a Medicare participant and that it conducts an internal review of the telemedicine practitioner's performance.¹⁵⁰ The receiving hospital must also ensure that the practitioner is privileged at that providing hospital and holds a license recognized by the state where the distant-site hospital is located.¹⁵¹ These provisions are important in that it would be time-consuming, difficult, and impractical for a hospital to go through the privileging process for a doctor who does not work directly in the receiving hospital.¹⁵² This procedure demonstrates how the issues concerning privileging and credentialing could be resolved on a larger scale if telemedicine were regulated on the federal level in a broader context.

¹⁴⁵ CMS, TELEHEALTH, *supra* note 6, at 2.

¹⁴⁶ HPIO, LOOKING AHEAD, *supra* note 11, at 8. Services covered include "office or other outpatient visits, . . . professional consultations, psychiatric diagnostic interview examination, neurobehavioral status exam, individual psychotherapy, pharmacologic management, end-stage renal disease-related services, individual . . . medical nutrition therapy," and follow-up telehealth consultations furnished by an interactive telecommunications system. *Id.* at 5 (citing 42 C.F.R. § 410.78(b) (2014)).

¹⁴⁷ CMS, TELEHEALTH, *supra* note 6, at 2.

¹⁴⁸ Credentialing and privileging concerns the procedures and guidelines that health care organizations utilize in assessing whether a professional is qualified to practice in the organization. Hoffman & Rowthorn, *supra* note 13, at 24. Most hospitals follow the Joint Commission's national standards regarding credentialing and privileging, which enforce CMS credentialing and privileging requirements. *Id.* at 25–26.

¹⁴⁹ 42 C.F.R. §§ 482.22(a)(3)–(4), 485.616(c)(2) (2014). This is significant because before July 5, 2011, CMS regulations required organizations utilizing telemedicine services to privilege every health care practitioner "as if the practitioner were on site." Hoffman & Rowthorn, *supra* note 13, at 26 (citation omitted); *see also* 42 C.F.R. § 482.22 (2014).

¹⁵⁰ 42 C.F.R. § 482.22 (2014).

¹⁵¹ *Id.*

¹⁵² Hoffman & Rowthorn, *supra* note 13, at 24 (explaining that privileging examines a practitioner's performance, takes into account services offered by the privileging hospital, and is conducted by peer review, making it a subjective process that is more difficult to do externally by a third party).

2. The Affordable Care Act

The Affordable Care Act includes provisions that address and encourage the use of technology in health care reform.¹⁵³ One of the stated objectives of the Affordable Care Act is to “[r]educe the growth of health care costs while promoting high-value,” and another is to promote the adoption and “meaningful use of health information technology.”¹⁵⁴ The inclusion of telehealth in the following provisions is noteworthy, in that it demonstrates that policy makers are recognizing the potential for telehealth to help alleviate some of the health care issues confronting the United States.

Section 2703 of the Affordable Care Act provides federal funding to states that provide “health homes” to eligible Medicaid beneficiaries who have two or more chronic conditions, one chronic condition and are at risk for a second, or a serious and persistent mental health condition.¹⁵⁵ Medicaid will provide 90% Enhanced Federal Medical Assistance Percentages for home health services, including comprehensive care management, care coordination, health promotion, comprehensive transitional care, patient and family support, and referral to community and social support services.¹⁵⁶ Health homes must implement an integrated care plan for beneficiaries that coordinates all clinical and non-clinical services necessary to support the beneficiaries’ health care needs.¹⁵⁷ These health homes must be both quality-driven and cost-effective.¹⁵⁸

The other three provisions of the Affordable Care Act that include telehealth technology as a means for reform provide for the assessment of new health care delivery models and also aim to improve the quality of care while reducing costs.¹⁵⁹ Section 3021 of the Affordable Care Act establishes a Center for Medicare and Medicaid Innovation within CMS.¹⁶⁰ The center will

¹⁵³ Zilis, *supra* note 23, at 198.

¹⁵⁴ *Goal 1: Strengthen Health Care*, HHS.GOV, <http://www.hhs.gov/strategic-plan/goal1.html> (last visited Feb. 12, 2015), *archived at* <http://perma.cc/NQ9B-YT94>. Provisions of the Affordable Care Act aim to improve patient outcomes, promote efficiency and accountability, ensure patient safety, encourage shared responsibility, and work toward high-value health care. *Id.*

¹⁵⁵ See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2703, 124 Stat. 119, 319 (2010) (codified at 42 U.S.C. § 1396w-4 (2012)); see also *Health Homes (Section 2703) Frequently Asked Questions*, MEDICAID.GOV, available at http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Health-Homes-FAQ-5-3-12_2.pdf (last visited Feb. 13, 2015), *archived at* <http://perma.cc/36NL-L7TP>.

¹⁵⁶ *Health Homes*, *supra* note 155.

¹⁵⁷ Zilis, *supra* note 23, at 198.

¹⁵⁸ *Id.* at 198–99.

¹⁵⁹ *Id.* at 198.

¹⁶⁰ See Patient Protection and Affordable Care Act § 3021, 42 U.S.C. § 1315a (2012); see also DEMOCRATIC POLICY & COMM’NS CTR., THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: SECTION-BY-SECTION ANALYSIS 22 (2009) [hereinafter PPACA].

“research, develop, test, and expand innovative payment and delivery arrangements”¹⁶¹ and will consider whether a state’s model incorporates technology such as “patient-based remote monitoring systems, to coordinate care over time and across settings,” in order to decide whether a state will receive a grant.¹⁶² Congress suggests that tele-ICUs are one such delivery model that the Center for Medicare and Medicaid Innovation should appraise.¹⁶³ Section 3022 of the Affordable Care Act directs Accountable Care Organizations to “coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.”¹⁶⁴ In addition, § 3024 calls for an Independence at Home Demonstration Program that is to last for three years and use “electronic health information systems, remote monitoring, and mobile diagnostic technology,” in order to test the programs’ efficiency in reducing hospital readmissions and emergency room visits.¹⁶⁵ These provisions offer reimbursement and reward incentives to providers that offer quality care at a lower cost.¹⁶⁶

IV. FEDERAL ACTION ENCOURAGING THE GROWTH OF TELEHEALTH

Given the history of physician licensure and the failure of the states to adopt uniform standards conducive to the practice of telehealth, the federal government should intervene to create a federal licensing system for the practice of telehealth and should expand Medicare coverage to cultivate the benefits telehealth offers. This federal regime would allow health care consumers to experience a higher quality of care, while lowering costs for health care services. Such a licensure system is constitutional under the Commerce Clause and the Spending Clause.

A. *Suggested Federal Regulation*

As demonstrated,¹⁶⁷ it is highly unlikely that the states will adopt a uniform standard for physician licensure in the near future, so the federal government should intervene in order to remedy the disparity in access between urban and rural communities. Likewise, the federal government should expand the services covered by Medicare to accommodate remote

ANALYSIS], available at <http://www.dpc.senate.gov/healthreformbill/healthbill05.pdf>, archived at <http://perma.cc/9QRY-28QN>.

¹⁶¹ PPACA ANALYSIS, *supra* note 160, at 22–23.

¹⁶² Patient Protection and Affordable Care Act § 3021(2)(C)(iv), 42 U.S.C. § 1315a (2012).

¹⁶³ Zilis, *supra* note 23, at 199.

¹⁶⁴ Patient Protection and Affordable Care Act § 3022, 42 U.S.C. § 1395jjj (2012).

¹⁶⁵ *See id.* § 3024, 42 U.S.C. § 1395cc-5 (2012); *see also* Zilis, *supra* note 23, at 201.

¹⁶⁶ Zilis, *supra* note 23, at 201.

¹⁶⁷ *See supra* Part III.A.1 (discussing the NLC and other licensure models).

patient monitoring, which as demonstrated by the VA hospitals, would help decrease health care spending in the United States.

1. *National Licensure for Telehealth Services*

The federal government should develop a separate national licensure system for telehealth services. This system should allow physicians with state licenses to apply to a national registry for approval, which would allow them to practice telehealth in any of the fifty states without having to obtain more than one license in addition to their original state license. This reform would alleviate the substantial burden placed on physicians and specialists wishing to offer telehealth services to underserved rural communities. A national council would determine the details of predetermined requirements for national licensure.¹⁶⁸ The licensure authority would ensure that those entering the profession are academically qualified, competent, and mentally and physically fit to provide activities covered by the license, the exact same inquiry currently performed by state boards when determining state licensure.¹⁶⁹ This council would be made up of representatives from each of the states. The resulting process should be as rigorous as applying for state licensure in most states, so that telehealth is not seen as a lesser form of medical practice. The predetermined requirements should include mandatory Continuing Medical Education (CME) hours, and the council should determine the amount of CME hours. Many states require CMEs for licensure,¹⁷⁰ so this mandate will ensure that physicians with national telehealth licenses are as qualified as physicians in states that require CMEs for licensing. A certain amount of the CMEs could be required to revolve around telehealth practices if the board finds this necessary.

The requirement that a physician hold a state license in order to maintain a national telehealth license would prevent states from losing valuable funding they receive through state licensure, which is one of the cited reasons why states are reluctant to accept a national licensure program.¹⁷¹ Requiring a separate federal license for telehealth in addition to state licensure would ensure that physicians still pay licensure fees in the state where they physically practice. In addition, the fact that the telehealth license is separate from the license required to physically practice in any of the states will further prevent

¹⁶⁸ The predetermined requirements would include criminal background checks, fingerprinting, Continuing Medical Education (CME) hours, verification that the applicant has a state license and that the applicant has not had a license revoked or restricted in any state, and proof of medical education and post graduate training. See *supra* Part III.A.1 for an understanding of why these particular requirements are necessary. The council would determine details, such as the amount of training and years of medical education.

¹⁶⁹ WAKEFIELD, *supra* note 17, at 8.

¹⁷⁰ Young & Alexander, *supra* note 86, at 169–75 (detailing various state practices).

¹⁷¹ Hoffman & Rowthorn, *supra* note 13, at 21 (“[A] national licensing scheme would take revenues away from state bureaucracies at a time when they are revenue starved.”).

the loss of funding, because physicians wishing to physically practice in other states would still be required to apply through the normal state licensure process.

States would be required to report disciplinary action to the federal program through a national database. There is already one such database established, the Federation Physician Data Center (FPDC), maintained by the Federation of State Medical Boards (FSMB), which collects state disciplinary data.¹⁷² The board, paid for through licensing fees, would have access to this database and receive notifications when disciplinary action by a state is reported. It would be up to the established board to decide if the disciplinary action justifies revocation of the national license. However, if a state license were revoked, the telehealth license would automatically be revoked.¹⁷³ So, the disciplinary action would be as harsh or harsher than the state imposed rules. This should lessen the concern voiced by state boards regarding monitoring the quality of care across jurisdictions.¹⁷⁴ A framework for evaluating disciplinary action would be established by the national council before the system is implemented.

In regards to telehealth malpractice cases, the council would decide which state's law will apply, which standard of care will apply, and whether or not there is a different standard of care applicable to telehealth as opposed to direct consultations.¹⁷⁵ This will reduce the uncertainty surrounding legal liability for

¹⁷² Aaron Young et al., *A Census of Actively Licensed Physicians in the United States*, 2010, 96 J. MED. REG. 10, 10 (2011), available at <https://www.nationalahec.org/pdfs/FSMBPhysicianCensus.pdf>, archived at <https://perma.cc/7R2E-4N56> (explaining that the FSMB maintains a "comprehensive central repository of state-based data" that contains information including biographical, educational, and disciplinary data about licensed physicians throughout the seventy different U.S. licensing jurisdictions).

When the FPDC receives physician licensure or disciplinary data, each record is matched to a master physician identity table using a set of algorithms This systematic process also allows the FSMB to track the same individual across multiple jurisdictions if more than one state license is sought by a physician.

Id. at 10–11.

¹⁷³ Only the state licensing board where the physician is licensed would have the authority to take direct action against a physician's state license. This is the approach taken by the NLC in regards to direct action on a nurse's anchor license. *See* WAKEFIELD, *supra* note 17, at 18–19.

¹⁷⁴ *See supra* note 115 and accompanying text.

¹⁷⁵ Several scholars argue that developing a separate standard of care for telehealth services is necessary. Compare Ameringer, *supra* note 8, at 70, 81–82 (arguing that the "interconnectedness" of licensure and discipline may be overlooked by a national scheme, but conceding that without a national standard there may be significant variation across states in disciplinary action for similar infractions), and Kelly K. Gelein, Note, *Are Online Consultations a Prescription for Trouble? The Uncharted Waters of Cybermedicine*, 66 BROOK. L. REV. 209, 250–51 (2000) (suggesting that a "virtual" national standard of care would create a uniform body of malpractice law to provide guidance to the states), with Kaspar, *supra* note 58, at 865 (explaining that a separate standard of care for telehealth

telehealth malpractice, and provide guidance to doctors practicing telehealth across state lines.¹⁷⁶ Also, in regards to patient privacy, the standard applied to licensed telehealth practitioners practicing telehealth would be the national standard as set out by HIPAA. States would be free to impose more stringent security measures for practitioners physically practicing in their state, but only the national standard would apply to telehealth practitioners when utilizing telehealth services over state boundaries.¹⁷⁷

In regards to telehealth services, hospitals would deal with credentialing and privileging issues by following the procedure similar to the one already outlined by the Medicare program, i.e., allowing hospitals to rely on credentialing and privileging decisions made by the hospitals where the practitioner providing the telehealth services is certified.¹⁷⁸ The hospital receiving the services would be required to establish that the physician has a telehealth license and a state license, and that the hospital providing the services conducts an internal review of the physician's performance. The receiving hospital would also be required to confirm that the physician is privileged at the hospital providing the services.¹⁷⁹ Before enacting the program, the council would meet with CMS and the Joint Commission for approval, which should not be a problem, because relying on the privileging and credentialing decisions of other hospitals has already been approved in the context of Medicare.

This model, creating a federal licensure program for telehealth services, is a more practical solution to relieve issues regarding physician licensure than other models that have been suggested by scholars or applied on a state-by-state basis.¹⁸⁰ As is evidenced by the NLC and other models, such as state based special purpose licenses and endorsement, it is highly unlikely that states will agree to a single licensing structure without federal intervention. Likewise, a national scheme for all physician licensure, although conducive to the practice of telehealth, would be an unrealistic proposal at this time. Implementing a national licensure program for all physician licensure would cause strong resistance from the states because they would lose valuable funding from licensing fees, and would lose all control over standards of care and licensing requirements. The argument for a national physician licensure system would also raise constitutional issues that would not be as logically

could account for peculiarities specific to telehealth, such as a diagnostic disadvantage, while still affirming liability for physicians that do not comply with regulatory guidelines, noting that Hawaii has developed such a standard).

¹⁷⁶ Gupta & Sao, *supra* note 22, at 434.

¹⁷⁷ See *supra* note 137 and accompanying text.

¹⁷⁸ See *supra* notes 148–52 and accompanying text.

¹⁷⁹ See 42 C.F.R. §§ 482.22(a)(3), 485.616(c)(2) (2014).

¹⁸⁰ See *supra* Part III.A.1 for an explanation of licensure models implemented on a state-by-state basis.

overcome by Congress's authority under the Commerce Clause.¹⁸¹ A federal license regulating telehealth would not take funding from states, and would still leave states the authority to regulate the general practice of medicine within their borders.

2. Expanding the Telehealth Services that Can Be Reimbursed Through Federal Programs

Currently, Medicare only reimburses for telehealth services that utilize an interactive audio and video telecommunications system that permits real-time communication between a patient at the approved originating site and a physician at a distant site.¹⁸² The federal program should expand coverage of telehealth services to include store-and-forward services, such as remote patient monitoring services that monitor diagnostic health indicators, including weight, insulin level, heart rate, and blood pressure.¹⁸³ Services provided in the home should be compensated similar to how the VA hospital system compensates such services, because these programs have been successful in lowering the costs of health care.¹⁸⁴ This would allow health care consumers to realize the full benefits that telehealth has to offer.

Through expanding Medicare to cover home telehealth services, states will recognize the economic benefits of home telehealth. Americans will also witness the increase in quality of care and patient satisfaction that come with allowing patients to remain in their homes. This could help motivate states to expand Medicaid coverage to mirror coverage under Medicare. Similarly, with the implementation of a federal telehealth-licensing scheme, states would become more familiar with telehealth and its benefits, and, therefore, be more open to expanding Medicaid coverage to account for this.

The federal government should implement a federal licensing system for physicians wishing to practice telehealth over state lines, and should expand Medicare coverage to include store-and-forward services such as remote patient monitoring. Although physician licensure is currently regulated state-by-state, the benefits of telehealth outweigh state concerns when limited to the narrow application of a national telehealth license. Although it may not be readily apparent, the constitutionality of such a system is evident.¹⁸⁵ Part IV.B explores this question of constitutionality further.

¹⁸¹ See *infra* Part IV.B. The connection of telehealth to interstate commerce is more apparent than for general physician licensure.

¹⁸² CMS, TELEHEALTH, *supra* note 6, at 2.

¹⁸³ HPIO, LOOKING AHEAD, *supra* note 11, at 2.

¹⁸⁴ See *supra* note 5 and accompanying text.

¹⁸⁵ See *infra* Part IV.B.

B. *The Constitutionality of Federal Regulations Regarding Telehealth*

The police power reserved to the states by the Tenth Amendment of the United States Constitution allows each state to individually regulate activities that affect the health, safety, and welfare of its citizens within its borders—and this had been considered to include the regulation of telehealth services.¹⁸⁶ While this proposition is generally accepted as true, several scholars have offered legitimate and convincing arguments for federal regulation in the health care field, based on federal authority granted by the Spending Clause and the Commerce Clause.¹⁸⁷ These arguments establish the constitutionality of a federal telehealth license.

States have police power over the practice of medicine where such regulation “furthers a legitimate state interest.”¹⁸⁸ This power does not mean that states have exclusive control over regulation where the Constitution grants Congress the power to regulate.¹⁸⁹ The Supreme Court does not interpret the Tenth Amendment to grant states exclusive control over particular areas, so “direct federal regulation of physicians should not falter on federalism grounds unless it falls beyond the reach of the commerce, spending, or other enumerated powers.”¹⁹⁰ Although the Supreme Court has recently invalidated regulations on federalism grounds in a variety of contexts,¹⁹¹ it has also allowed federal law to preempt state law in contexts related to public health.¹⁹² As one scholar has stated, “[t]he historic role of the states in licensing health

¹⁸⁶ See Volkert, *supra* note 80, at 165; see also U.S. CONST. amend. X; Zilis, *supra* note 23, at 214.

¹⁸⁷ E. Donald Elliot et al., *Administrative “Health Courts” for Medical Injury Claims: The Federal Constitutional Issues*, 33 J. HEALTH POL. POL’Y & L. 761, 767–77 (2008); Gupta & Sao, *supra* note 22, at 417–26; Lars Noah, *Ambivalent Commitments to Federalism in Controlling the Practice of Medicine*, 53 U. KAN. L. REV. 149, 169–70 (2004). See generally Young & Alexander, *supra* note 86, at 194–95 nn.356–65 (discussing scholarly work in the health care arena in regards to federal authority to regulate general physician licensure, outside of the context of telehealth).

¹⁸⁸ Gupta & Sao, *supra* note 22, at 415 (citing Pharm. Mfrs. Ass’n v. FDA, 484 F. Supp. 1179, 1187–88 (D. Del. 1980), *aff’d*, 634 F.2d 106 (3d Cir. 1980)).

¹⁸⁹ *Id.* at 415.

¹⁹⁰ Noah, *supra* note 187, at 161 (explaining Supreme Court cases addressing the issue of federal power over medical practice).

¹⁹¹ *Id.* at 155–56 (explaining that in *United States v. Morrison*, 529 U.S. 598 (2000), the Supreme Court struck down the Violence Against Women Act as invalid on federalism grounds, but in *Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525 (2001), the Supreme Court held that federal regulation regarding tobacco advertising preempted state regulation).

¹⁹² Gupta & Sao, *supra* note 22, at 416–17. Congress has enacted regulation in the health care arena, and this counters the argument of state exclusivity. *Id.* For example, the Mammography Quality Standards Act requires facilities to be FDA certified in order to perform mammograms, and the Food, Drug, and Cosmetic Act regulates health care delivery technologies. *Id.*

care professionals and defining their scope of practice does not foreclose the possibility of concurrent federal regulation.”¹⁹³

Telehealth has a substantial effect on interstate commerce, so Congress arguably has the authority to regulate the practice of telehealth under the Commerce Clause.¹⁹⁴ Health care has developed into a national—or even global—commercial industry.¹⁹⁵ The progress of advanced technologies has allowed practitioners to provide services from a distance, and patients travel across state lines for procedures not available in their home state.¹⁹⁶ Many health care professionals are part of national chains or work within managed care networks that span over state borders. These new realities exemplify the fact that the historically local view of the practice of medicine is no longer accurate.¹⁹⁷

The referenced arguments apply to general regulation of the health care industry, separate from telehealth. The advanced technologies utilized by telehealth services, and its general nature, further erode the relevance of state borders.¹⁹⁸ The argument that telehealth affects interstate commerce is even stronger than the argument regarding federal regulation for general physician licensure because of telehealth’s direct link to interstate commerce.¹⁹⁹ The regulation of interstate telemedicine has an effect on the price and market conditions of health care services and regulations governing whether telemedicine providers can practice over state boundaries provide a direct link to interstate commerce.²⁰⁰ Consequently, interstate telemedicine likely falls under all three categories of permissible federal regulation, allowing Congress to legislate under the power granted by the Commerce Clause.²⁰¹

The Spending Clause presents another viable route to passing constitutional muster in regards to federal health care regulation, and some

¹⁹³ Noah, *supra* note 187, at 168.

¹⁹⁴ Volkert, *supra* note 80, at 177 (citing *United States v. Lopez*, 514 U.S. 549, 559 (1995)).

¹⁹⁵ Gupta & Sao, *supra* note 22, at 417 (explaining that this development places state regulation over telehealth in conflict with the Federal Commerce Power).

¹⁹⁶ *Id.*

¹⁹⁷ Noah, *supra* note 187, at 169 (noting that health expenditures are a large part of the United States economy, with clinical services totaling \$286 billion annually, and health care costs totaling \$1.3 trillion annually).

¹⁹⁸ *Id.* at 170.

¹⁹⁹ Gupta & Sao, *supra* note 22, at 429.

²⁰⁰ *Id.*

²⁰¹ *Id.* at 427 (explaining that Congress has the power to regulate interstate commerce if the regulation passes the “substantial effect” test established in *United States v. Lopez*, 514 U.S. 549 (1995), and concluding that interstate telemedicine falls under all three categories of permissible regulation, where it must only fall under one to be valid). “[F]ederal legislation is permissible if it falls under one of the following types of activities: (1) Regulation of use of channels of interstate commerce; (2) Regulation and protection of instrumentalities of interstate commerce; or (3) Regulation of activities having substantial effect on commerce.” (footnotes omitted). *Id.*

scholars believe it is an even stronger ground for federal authority.²⁰² The Spending Clause gives Congress the power to provide for the general welfare of the United States.²⁰³ The Supreme Court has not imposed any significant limitations on the spending power, and the Court interprets the power to spend for the general welfare broadly.²⁰⁴ The federal government, under Congress's power to spend for the general welfare, provides over 40% of health care spending.²⁰⁵ Congress would be able to regulate federal telehealth licensing so long as it conditioned the receipt of federal health care funds on cooperating with the program, and provided adequate notice of the condition to the states.²⁰⁶

Federal preemption in regards to physician licensure for telehealth services is necessary for the substantial benefits of telehealth to be realized, and Congress has the power to enact such regulation under the Commerce or Spending Clauses of the Constitution. The states will likely resist such regulation,²⁰⁷ but their reasons for doing so are misguided given that they will still have full power to regulate general physician licensure, they will still receive the revenue from general licensure, and the safeties provided by the proposed solution ensure that physicians receiving telehealth licensure are qualified.²⁰⁸

V. CONCLUSION

The health care system of the United States is in a state of disarray, and the time is ripe for federal intervention in order to implement regulations conducive to the practice of telehealth across state lines and within the home. Given national economic distress, and the fact that the United States spends considerably more money on health care than other countries, without

²⁰² Young & Alexander, *supra* note 86, at 195 n.362 (citing Elliot et. al., *supra* note 187, at 774); *see also* Noah, *supra* note 187, at 169 (“[T]he federal government could regulate health care professionals without ever having to invoke the Commerce Clause.”).

²⁰³ U.S. CONST. art. I, § 8, cl. 1; *see also* Gupta & Sao, *supra* note 22, at 430 (explaining that under the Spending Clause, Congress has the power to regulate where: “(1) [t]he federal regulation in question advances the general welfare; (2) [t]he federal regulation in question is clearly expressed to recipient states and bear some relationship to the spending program; and (3) [t]he federal regulation is voluntarily accepted by States.” (footnotes omitted)).

²⁰⁴ Gupta & Sao, *supra* note 22, at 429–31 (explaining that Congress’s power under the Spending Clause is broad, and is limited “only by the requirement that it shall be exercised to provide for the general welfare of the United States”); Noah, *supra* note 187, at 169.

²⁰⁵ Young, *supra* note 86, at 195.

²⁰⁶ *Id.*; *see also* Gupta & Sao, *supra* note 22, at 431–33 (explaining why the three requirements for power under the Spending Clause are met in relation to federal health regulation).

²⁰⁷ Hoffman & Rowthorn, *supra* note 13, at 21–22.

²⁰⁸ *See supra* notes 171–76 and accompanying text.

coordinate health outcomes, the time has come to implement and utilize the health technology already available to remedy the problem. In today's society, the use of communications technology in everyday life is enormous, and the development of new and promising information communications technologies shows that the nation is ready for its integration into health care. Problems of access, quality, and the cost of health care services can all be partially alleviated by telehealth.

Telehealth has the potential to improve access to all levels of health care, support patient-centered care at a lower cost in local environments, improve the efficacy of both in-home and facility provided chronic disease management, and promote efficiency in clinical decision-making and prescribing medication. Significantly, telehealth can help remedy the problem of provider shortages in rural areas by facilitating treatment from a distance. While this is the case, the current regulatory structure in place has not grown to encompass the novel legal issues raised by telehealth practices. State regulation of telehealth varies greatly from state to state, and this variation is one of the major impediments preventing telehealth's widespread implementation. However, multiple studies have found that the potential benefits of telehealth outweigh the cost of implementation, and the success of the VA hospitals and prisons in reducing cost while increasing quality and efficiency demonstrate this positive outcome.

Federal preemption in regards to physician licensure for telehealth services is necessary for the substantial benefits of telehealth to be realized, and Congress has the power to enact such regulation under the Commerce or Spending Clauses of the Constitution. Likewise, the federal government should expand Medicare to cover home telehealth services in order to experience the cost savings realized by VA hospitals, which in turn would spread awareness of the usefulness of telehealth. The current climate of health care reform in the United States and the need for some type of economic relief demands that telehealth be examined as one part of a larger solution.

